CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Contents

Full Report

Child

- L.S.

Date of Child's Birth

- [redacted] 2020

Date of Fatality

- August 2020

Child Fatality Review Date

- Nov. 19, 2020

Committee Members

- Patrick Dowd, JD, Office of the Family and Children's Ombuds, Ombuds Director
- Jordan Tracy, MSN, RN, Tacoma Pierce County Health Department, Public Health Nurse II, Strengthening Families
- Ly Dinh, MSW, Department of Children, Youth, and Families, Quality Practice Specialist Region 5
- Roberto Terrones, SUP, Consejo Counseling and Referral Service, East Pierce County Program Manager
- Tarassa Froberg, Department of Children, Youth, and Families, Statewide Child Protective Services and Family Voluntary Services Program Manager

Facilitator

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Executive Summary

On Nov. 19, 2020, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to assess DCYF's service delivery to L.S. and RCW 74 family.[2] RCW 74 will be referenced by RCW 74 initials throughout this report.

On Aug. 24, 2020, DCYF received an intake from the sheriff's office stating L.S. had died. The father came home to find L.S. unresponsive. The mother, L.S., and L.S.'s brother had fallen asleep on the couch in the living room. An intake was created and assigned for a Child Protective Services (CPS) investigation. The investigation resulted in an unfounded finding for abuse or neglect.

At the time of RCW 74 death, L.S.'s family had an open Family Voluntary Services (FVS) case. The family completed FVS, and the case closed on Nov. 4, 2020.

The CFR Committee (Committee) includes members with relevant expertise selected from diverse disciplines within the community. Committee members have not had any involvement or contact with L.S. or RCW 74 family. The Committee received relevant documents, including intakes, case notes, and other DCYF documents maintained in DCYF's electronic computer system.

The Committee interviewed the CPS caseworker, CPS supervisor, FVS supervisor, and area administrator.

Case Overview

On April 6, 2020, DCYF received an intake regarding L.S.'s 14-year-old half-sister. RCW 13.50.100 The intake alleged concerns that the mother was not adequately addressing the 14-year-old's mental well-being. This intake screened in for a CPS/Family Assessment Response (FAR).[3]

At the time of this intake, the mother had five children, three daughters, and two sons. Except for one son, all of those children lived with the mother. The assigned CPS/FAR caseworker made contact with the father of the 14-year-old child. He is the father to the three oldest girls who live in the mother's home. The following day, the caseworker contacted the mother and discussed the intake. During that discussion, the caseworker discussed Infant Safe Sleep because the mother indicated she bed shares with her RCW 74.13 -month-old son.[4] The mother stated her son refused to sleep anywhere else, including the playpen in their home. The caseworker made an appointment to interview the three older girls at their mother's home.

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[1] "A child fatality or near-fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." Given its limited purpose, a child fatality review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers.
The Committee has no subpoena power or authority to compel attendance and generally hears only from DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals.

[2] No one has been criminally charged related to L.S.'s death; therefore, no one is named in this report.

[3] "Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been screened in for intervention." See: https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response

[4] https://www.dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention

During the initial face-to-face interview, the girls did not disclose any abuse or neglect in their mother's home. The 14-year-old identified that the concern reported in the intake stemmed from comments she made on a school website. RCW 13.50.100. She discussed that the current COVID-19 pandemic made it impossible for her to spend time with her friends and that it had a negative impact on her mental well-being. She denied any abuse or neglect in her mother's home. One other sister was also interviewed. The third child was at another location. The caseworker gave Infant Safe Sleep material to one of the girls to provide to their mother. Due to concerns regarding COVID-19 in the family home, the caseworker did not perform a walk-through of the home, and the interview with the mother was conducted by telephone.

During the caseworker's telephone interview with the mother, the caseworker discussed the concerns alleged in the intake. The mother shared that she lived with her three daughters and infant son and that her son's father lived in her home a majority of the time. The mother also shared that she had another son who lived with his biological father in RCW 74.13.515. According to the mother, the father made false allegations against her and gained full custody. The mother was not granted visitation. The mother also discussed her love of working and stated she went back to work only four days after giving birth to her infant son. She discussed her relationship with her infant son's father. The father stayed at the family home a majority of the time, but there were periods when he would not return home for days at a time. He also did not regularly financially support the family.

The mother shared that she had RCW 74.13.520 but denied any mental health, substance use, or domestic violence history. The caseworker and mother discussed addressing the mental well-being of the 14-year-old and how to incorporate the extended family as natural supports. The 14-year-old identified her grandmother and an aunt as support and people she could turn to when she wanted to talk. The mother supported that but also explained that her family viewed mental health concerns as something you just learn to deal with and do not talk about.

On April 21, 2020, DCYF received another intake. This intake alleged that the mother had been in a hospital emergency department on April 11, 2020. RCW 74.13.520. The mother also had a positive drug screen for RCW 74.13.520, RCW 74.13.520, RCW 74.13.520, and alcohol. RCW 74.13.520. This intake screened out.

That same day, the CPS caseworker finally reached the mother by phone. The caseworker had been trying to reach her for a few days prior to the April 21 intake. This concerned the CPS caseworker because prior to April 15, the mother had been very communicative. The mother stated her phone broke and was now using a phone app. The caseworker told the mother that to close the case, the caseworker needed to interview her boyfriend, who was the father of her infant son. The mother reported that he had not been home the past few days.

On April 27, 2020, the caseworker emailed the 14-year-old's school counselor to discuss the concerns identified in the first intake. In his response, the counselor stated RCW 13.50.100. The counselor shared RCW 13.50.100.

On RCW 74.13.515, 2020, DCYF received another intake. This intake reported L.S. had been born. At L.S.'s birth, the mother tested positive for RCW 74.13.520. The referent stated the mother tested positive for RCW 74.13.520 and alcohol somewhere else but did not have those details. L.S. was born at RCW 74.13 520 gestation and would

remain in the hospital for about two months. The birth occurred in RCW 74.13.515 state. Records indicated the other positive drug screen had been reported to DCYF on April 21, 2020. The mother talked about experiencing RCW 74.13.520. There was no information about domestic violence, and there was no prenatal care. The hospital staff reported good eye contact between the mother and L.S. and that she had been loving and appropriate. They reported the mother RCW 74.13.520. This intake was assigned as a Risk Only CPS investigation.[5]

The case was initially called into the RCW 74.13.515 Department of Human Services (DHS) because the birth occurred in RCW 74.13.515. DHS sent out a caseworker to the hospital. The DCYF caseworker contacted the DHS caseworker. The DHS caseworker shared that L.S.'s mother denied RCW 74.13.520 use. The mother thought maybe she tested positive from sharing her brother's cigarette because he uses drugs. The mother denied any drug use by L.S.'s father. She said they would both submit to urine tests.

The DCYF caseworker then called the hospital social worker. The original social worker was unavailable, but the one on shift assisted the caseworker. The caseworker was told the hospital was waiting to gather meconium for further testing because L.S.'s urine test was negative, but RCW 74 mother was positive for substances. Meconium is the first fecal matter from a newborn after birth. The meconium lines the baby's intestines during the pregnancy and often holds toxins and substances longer and is often used for drug screening in situations similar to this one. The caseworker referred both of L.S.'s parents for urine tests that same day. She notified the mother of the referral. The mother responded affirmatively, stating they would provide their samples.

On May 1, 2020, the caseworker followed up with the initially assigned hospital social worker. The hospital social worker was familiar with the parents from the previous RCW 74.13.520 birth of their son. She said they had always been polite and appropriate, and the hospital never had any concerns until the positive urinalysis. The social worker shared that the mother also did not have prenatal care for her son's birth and that the mother reported it was because of her employment.

As part of her regular process, the caseworker requested records from multiple law enforcement agencies. She also completed an interview with L.S.'s father by phone. The caseworker and father discussed discipline, supports, employment, his role in parenting the older children, and his criminal history. He denied any substance abuse, domestic violence, or mental health concerns. They also discussed the concerns from the April 6 intake. L.S.'s father believed the mother's positive RCW 74.13.520 urinalysis came from sharing a cigarette with her brother. He stated he "would not let her" use substances. When asked about her alcohol-positive urinalysis, he stated, "She would have some red, white wine. She has been told that [was] okay to have a glass. It was not to the point where she was drunk…".

The caseworker followed up with the mother by telephone to discuss the urinalysis and prenatal care. The mother stated she set up a prenatal visit, but L.S. was born before the appointment occurred. When asked about the alcohol-positive urinalysis, she said she would drink a glass of wine but not to the point

[5] CPS Risk Only is an intake that alleges, "imminent risk of serious harm and there are no allegations of child abuse or neglect." See: https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response

of intoxication. The caseworker asked to set up a time for a home visit and to go over safe sleep in the home. They discussed what support the agency could offer the family as well.

On May 5, 2020, the caseworker again spoke with the hospital social worker. The meconium results came back positive for RCW 74.13.520. L.S. was not exhibiting complications or signs of withdrawal.

On May 7, 2020, the caseworker arrived at the family's home. She met with the mother and two of her children. No safety concerns were noted during this contact. The mother was emotional when discussing L.S. and the positive meconium test. The mother cooperated with requests for the release of information from the hospital and prenatal care clinic.

On May 12, 2020, the caseworker received records from the mother's prenatal clinic. The caseworker then called the physician. The doctor reported he had known the mother for a few years. He had not had any concerns about drug use. He stated she was a high-risk during pregnancy. He said the mother had an appointment with him for prenatal care, but she went into labor on the same day. The caseworker previously requested that the mother provide a urine sample through this physician. The physician reported the requested urinalysis was negative for substances.

Another caseworker in the office spoke with the father's aunt. She did not report any concerns and believed both parents were "…doting, loving and good with the children." She believed both parents were bonded to their children and that L.S.'s father had a father-like relationship with the older girls. She did not have any concerns about substance abuse.

On May 29, 2020, DCYF received an intake stating historical information about the family and alleging that L.S. was the second child born positive for drugs at birth. The referent stated when the mother visited L.S. at the hospital the previous night; she was drunk. RCW 13.50.100 . The referent also stated that the mother was drinking heavily because she was not using "…RCW 74.13 and RCW 74.13.52…" and that the children do not have beds. The caller alleged that the mother goes out and gets "wasted," leaving the older children to care for the younger children. The referent reported the kids say they want to kill themselves because they hate it at their home. This information was called into RCW 74.13.515 DHS, and they sent it to DCYF. The intake was screened out because there was an open CPS investigation regarding the mother's alcohol and drug use, and there were no allegations she had acted in an unsafe manner with the newborn at the hospital.

The office staffed the case for transfer to FVS, and it was decided that it would be appropriate to hold a Family Team Decision Meeting (FTDM) due to the concerns reported in the May 29 intake. On June 1, the caseworker discussed the FTDM with the parents. They were encouraged to invite extended family and supports to join the meeting. The caseworker expressed concerns regarding substance use by the mother. L.S.'s father stated he believed the mother was experiencing RCW 74.13.520 .

The FTDM was held on June 4, 2020. The parents were engaged and cooperative. The agency and parents agreed to voluntary services. Initially, the agency recommended Homebuilders, an intense, short-term, in-home service. However, the mother desired a longer-term service that could help her stability. The agency and parents agreed that the agency would refer the family to Family Preservation Services (FPS) based on the mother's request and identified struggles. FPS is a longer-term service where providers come to the parent's home and work on identified risk factors or safety threats. Its purpose is to support the home and work to prevent placement of the children in out-of-home care.

The FVS supervisor conducted a health and safety visit on July 9, 2020. The mother discussed that her RCW 74.13.515 was using a portable monitor for RCW 74 breathing due to RCW 74 RCW 74.13.520 birth. The FVS supervisor discussed what appeared to be a Mongolian spot, a type of birthmark, on L.S. and asked the mother to document it in medical records because the spots often look like bruises. They discussed Infant Safe Sleep and Period of Purple Crying.[6] The mother expressed financial concern for the family due to her lack of employment. She also shared that she was working with her primary care physician to address her RCW 74.13.515. She asked for beds for her older children. The three older girls were out of state for an extended visit with relatives. This was a planned visit over the summer and was not related to the CPS investigation. The mother would not allow the FVS supervisor to go upstairs to view L.S.'s sleeping environment. The mother stated it was because the father was sleeping. When the caseworker continued to request, the mother called the father, and he brought down the bassinet. Due to a desire to establish a relationship with the family, the FVS supervisor did not push the issue further. However, he did call the CPS caseworker after leaving the home to discuss this with her and verify that she had, in fact, been allowed upstairs previously, which she confirmed.

The FVS worker assigned to the family left her role. The CPS caseworker assisted the FVS unit by covering some health and safety visits. The next visit with the family occurred on July 30, 2020. The family was on their way to California due to a family emergency. The visit occurred by video chat. The mother reported things were going well for them. She stated the doctors did not have concerns about L.S. and that L.S. was eating well and growing. The mother reported she was up every couple of hours caring for L.S. The older girls remained out of state with relatives but were reportedly doing well. The caseworker asked about the mother's alcohol intake. The mother reported she had not drank anything and that she "…learned my lesson. I am not going to do that again." The father agreed that the mother was not drinking. They discussed that the mother had met with the FPS provider three times, and the mother said it was going well. When asked about the father's engagement with FPS, the mother stated she felt the services were for her and that she needed them. She did not ask him to participate. The mother also reported that the FPS worker never asked that the father participate, but they would comply if she did. The mother also reported she was seeing her own therapist and was on medication for RCW 74.13.520.

Another health and safety visit occurred on Aug. 11, 2020, but was in person. The caseworker and the family reviewed the same topics as in previous visits and again reviewed safe sleep. The family had a bassinet and pack-n-play. Both parents were present and engaged in the visit.

On Aug. 21, 2020, the caseworker conducted another health and safety visit. The mother reported that L.S. was constipated and not feeling well, so they were up a lot the previous night and were tired. She planned on calling the pediatrician for assistance. No other concerns were noted.

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[6] The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. "The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age." See: http://www.purplecrying.info/what-is-the-period-of-purple-crying.php.

living room. An intake was created and assigned for a CPS investigation. The investigation resulted in an unfounded finding for abuse or neglect. The family completed FVS, and the case closed on Nov. 4, 2020.

Committee Discussion

The Committee discussed the substance use by L.S.'s mother. There was discussion that sometimes DCYF staff look at substance use as addiction or nothing, meaning the nuance of misuse that has consequences (such as a Driving While Under the Influence [DUI] criminal charge) is often not considered as impactful as a diagnosis of addiction. That is not to say that there were no concerns or that this was not considered. With the ongoing positive urine tests from the hospital RCW 13.50.100, the Committee discussed that it may have been beneficial to have had a substance use assessment. L.S.'s mother was also taking medication, and a consultation with a subject matter expert in toxicology to discuss any interaction between the medications and substances identified in the urine tests may have been helpful. The conditions of her being a new mother caring for two young children, including one with special medical needs, combined with her dealing with RCW 74.13.520, sleep deprivation, and substance use or misuse, created a higher risk of abuse or neglect for vulnerable children.

While it was not required by policy, there was discussion that Plan of Safe Care utilization may have been beneficial. Plan of Safe Care requires DCYF staff to assess the infant and parents regarding any supports needed and for the staff to share this document with the parents. However, this was not required because L.S. was not identified as substance-affected at birth.

The case was initially transferred to an FVS worker who handled the case for about three weeks. That staff person was not available to the Committee to be interviewed and did not document any actions while she was assigned to the case. That staff person's supervisor shared with the Committee that the staff person's regular practice was to meet with families for up to three hours, gather in-depth details about each parent, and document that in a case note. This was discussed because there was no case note or other documentation that gave in-depth details expected of FVS cases.

One of the Committee members discussed "alarm fatigue" and thought that the mother was possibly struggling with this as well. An article published in 2013 states, "Research has demonstrated that 72%-99% of clinical alarms are false. The high number of false alarms has led to alarm fatigue. Alarm fatigue is sensory overload when clinicians are exposed to an excessive number of alarms, which can result in desensitization to alarms and missed alarms. Patient deaths have been attributed to alarm fatigue."[7] The Committee discussed that the mother mentioned her struggle and concern with the alarms from L.S.'s monitor multiple times with no solution offered to her by the pediatrician. There was some thought that this may have played a role in the mother's decision to stop utilizing the monitor.

This case was in an office that borders another state. There are legal restrictions prohibiting DCYF staff from crossing state lines into other states and conducting assessments or contacts, even if the cases are open to our agency. This was particularly challenging for this office because the critical care medical facilities in the area were in the other state. Specific to this case, it prohibited DCYF staff from face-to-face contact while members of the family were out of state, including L.S. This is an ongoing issue identified by counties impacted by state borders.

[7] https://pubmed.ncbi.nlm.nih.gov/24153215/

Findings

The Committee identified areas where improvements in casework could occur. The Committee did not attribute any of the identified areas for improvement as causing or contributing to the fatality.

The Committee identified that the FVS case plan should have been shared with the family and participants. Practices and Procedures Policy 3000 states, “Develop a case plan with the family based on the assessment of the family’s needs. The case plan must address the moderately high- or high-risk factors and the identified safety threats for the child.” Under Policy and Procedures 1100 Child Safety, 1150 Case Plan, the policy states the plan, “Be provided to the parent or legal guardian.” While the parents were a part of the planning process, there was no documentation that the case plan was physically shared.

The Committee also believed that the random urinalysis testing should not have stopped once the case transferred from CPS to FVS. They believe it would have been beneficial to continue monitoring after the case was transferred.

The Committee believed that DCYF should have conducted and documented an assessment of L.S.’s medical needs, including RCW 74 breathing monitor's purpose, expectation, and utilization. They understood that L.S.’s next oldest sibling RCW 74.13.520 and that the family did not experience any issues with his care, but the Committee believed the added stress of the impacts from the global pandemic, two RCW 74.13.520 children close in age, untreated mental health needs of the mother, misuse or abuse of substances, and the father’s inconsistency with physically and financially supporting his family created a much higher risk to L.S. than it had for RCW 74 brother. As part of this process, it may have been beneficial to gather information from the pediatrician and have a two-way conversation regarding the family and identified needs and risks.

Recommendation

The Committee identified that this case was an example of possible misuse of substances and not an addiction issue. This is a nuance that is often difficult for staff to discern. More collaboration with substance use professionals may have been helpful in this case. DCYF used to have substance use treatment professionals housed in field offices. These providers were available to help educate staff or discuss challenging cases. They also went into the field with staff. The Committee recommends that DCYF work toward either a collaborative relationship as previously described or create a system for field offices to build that relationship and/or a possible hotline-like system for staff to access professionals in this field to aid in cases where substance use has been identified.